nucleus in the right half of the pons, between the sensory fifth nucleus, the trapezium, and the root of the abducens. Under each case the author gives able arguments justifying the diagnosis.

11. *Spinal Muscular Atrophy following Lead Poisoning in a Case of Infantile Poliomyelitis.*—The muscular atrophy began in the patient, who was first a lead moulder and then a compositor, at the age of 20, and affected all parts except the muscles of the face, neck, and lower left leg. The atrophy commenced in the right leg, which from childhood on was shorter than the left, the result of poliomyelitis. From the age of 25, the patient also suffered from dermatitis herpetiformis.

12. *A Case of Extensive Disease of the Vessels and Meninges of the Brain and Cord in the Early Stages of Syphilis.*—The patient was a man of 43, who had a tuberculous history. Six months after infection he sustained, without loss of consciousness, a left-sided hemiplegia, which disappeared in 3 weeks. Two months later there was a severe headache, which yielded to specific treatment. Six months after the first appearance of cerebral phenomena, death occurred in an attack of right-sided hemiplegia, with symptoms of vagus paralysis. The autopsy showed a fibrinous pleurisy and lobular pneumonia; and in the brain extensive changes in the arteries and veins, in the form of periarteritic and endoarteritic, meningitic processes at the base of the brain in the neighborhood of the right frontal convolution and in the cord. Perineuritic and endoneuritic changes of the basal nerves and of the spinal roots, and softening in the lenticular nucleus and in the pons.

13. *A Case of Paralysis Agitans combined with Symptoms of Myxedema.*—Lundborg believes that myoclonus familiaris and paralysis agitans are both due to disease of the thyroid gland, and calls attention to the analogy which others have also observed, between paralysis agitans and exophthalmic goiter. He reports the case of a woman of 54, who in addition to paralysis agitans, had a number of the symptoms of myxedema. At the autopsy the thyroid gland was found small, with no middle lobe. Microscopic examination of the right lobe showed chronic interstitial changes, as well as a degeneration of the alveoli. The left lobe was the seat of cystic change. The author assumes that a thyroid so altered furnishes a pathologic secretion which is capable of producing a profound alteration in the nervous system. RIESMAN.

MISCELLANY.

THE TREATMENT OF MORPHINOMANIA. O. Jennings (Lancet, Aug. 10, 1901).

Dr. Jennings insists that the mere suppression of the habit of taking morphine such as can be assured when a patient is under restraint is no proper cure, and that unless the craving for the drug is removed the habit will of a certainty return when the patient regains his liberty and when the conditions which have led to the taking of the morphia again arise. In regard to this craving, one must differentiate, when it will be found that it occurs in two forms. Hypodermic injections of morphine seem to give energy and "go," and it is for this reason that the syringe is resorted to on the slightest pretext. It is, says Dr. Jennings, the exact equivalent of brandy nipping. Thus one form of craving is a desire for the purely stimulating effect of the syringe. This can with comparative ease be got over by the exercise of some self-control, or by a moderate amount of compulsion, so long as morphine in some other form is substituted. But the craving for the morphine itself is another matter. The morphine *habitué* becomes so dependent upon the drug that, quite independently of the immediate reviving effect which results from the use of the syringe, he depends, not merely for happiness, but for bodily comfort, upon the regular ingestion of a certain daily dose of morphine, the lack of which is the cause of the miserable wretchedness that accompanies the sudden suppression of the opium habit. One must bear in mind that morphine is a stimulant, and especially a cardiac stimulant, and that not a few of the depressing effects of the sudden cessation of its use are due to the enfeebled action of the circulatory apparatus which immediately results. Hence the necessity of administering some form of cardiac tonic or stimulant while the morphine is being reduced. Again, it will be observed that the morphine *habitué* suffers greatly from "hyperacidity of the stomach and organism generally." No doubt much of the sinking and distress which these patient complain of is primarily due to this sour condition of stomach, and although the morphinomaniac will fly to morphine for the mitigation of this as of every trouble, still there are other ways of relieving it, such as by the administration of alkaline stomachics. Hence the great utility of bicarbonate of soda in the treatment of the morphine habit. In fact, in treating this condition it is not sufficient merely to cut off the drug. One must do all in one's power to remove every cause of discomfort, and to protect from every cause of distress, knowing as we do that in these patients the craving which is the source of mischief is not a mere vicious desire for an unnatural stimulation, but is often a very natural longing to take what experience has shown to be the shortest way of getting rid of distressing feelings of many kinds.

In the treatment then of a case of morphinomania the first thing to do, according to the author, is to simplify the case by stopping the use of all other stimulants—alcohol, cocaine, or whatever they may be—which the patient may be taking; and it is comparatively easy to do this, for the morphine is what the patient craves for, and he will give up everything for its sake. Having then insured that we have but one vice to deal with, the next thing is to get rid of the use of the syringe by substituting some less harmful mode of administration; and this again ought not to be inordinately difficult; the patient can be persuaded to give up his temporary joy if we will allow him the means of escaping the continual misery which deprivation, or even material diminution of his daily dose of morphine produces. Dr. Jennings strongly advises that the morphine given for this purpose should be administered by the rectum. Of course the amount given in this way will have to be larger, perhaps twice as large as that taken hypodermically. But that does not matter. The patient is weaned from the constant desire for the immediately stimulating effect of the syringe. When this is accomplished, we must gradually reduce the dose; as quickly as possible, but at the same time as slowly as is necessary to effect a cure without producing distress; and with the object of warding off this distress, we must administer cardiac tonics such as sparteine or digitalis. In some cases nitroglycerine is useful. Then, in view of the almost constant presence of hyperacidity, bicarbonate of soda should be administered; and lastly one must remember that the hot-air bath—the Turkish bath followed by massage and the cold douche—is one of the best of sedatives, and perhaps also tends to eliminate some of the toxic material which tends to accumulate in the blood of these "acid" patients. At any rate the use of the hot-air bath is of great service not only during the process of reducing the morphine but also afterwards. It is very important that as the morphine is reduced the patient should be kept to a strictly moderate and as a general rule a non-alcoholic régime. The tendency is for these patients, as they recover, to eat too much, which again brings on hyperacidity, and this in turn leads to a renewal of the craving. To prevent this a simple life with a fair amount of exercise and the regular use of Turkish baths is to be advised. The great thing is to get rid not merely of the morphine but of the craving for it; and this cannot always be done by strength of will, by good resolutions, or even by subjection to restraint, unless attention be paid to the conditions which lead to the desire for the drug, and also to the discomforts which follow the cessation of its use.

JELLIFFE.

DIE JUVENILE FORM DER PROGRESSIVEN PARALYSE (Juvenile Form of Progressive Paralysis). J. A. Hirschl (Wiener klin. Wochenschrift, No. 21, 1901, p. 515).

During the last ten years twenty cases of juvenile paretic dementia have been observed in Krafft-Ebing's clinic. The age of twenty years is taken as the dividing line between the paresis of youth and that of adult life. Hirschl, who reports these cases, has found that in juvenile paresis hereditary syphilis and neuropathic taint are very common. In seventeen of the twenty cases hereditary syphilis was definitely shown, and in another case it was probable. Nine cases occurred in mentally deficient children. Twelve were in males and eight in females. The disease in these twenty cases began between the ages of eight and twenty years. Most of the patients had not reached puberty; as nine of the males and five of the females were sexually undeveloped. The average duration of the disease was three years and three-quarters, although two cases lasted seven years.

SPILLER.

REPORT OF A CASE OF CEREBELLAR TUMOR; DEATH; AUTOPSY. D. A. K. Steele (The Chicago Clinic, vol. xiii, No. 1).

The patient was a boy of thirteen. At the time of birth he was almost asphyxiated, being resuscitated after considerable effort. No instruments were used. At the age of four years he had malarial fever. When six years old he manifested abnormal nervousness. This passed off in about six months. When about eight or nine years old he suffered from severe epistaxis, and in his eleventh year he had what were called bilious attacks. The contents of the stomach were ejected with great violence. It was supposed that he was suffering from toxemia due to bile absorption, which caused the headaches, jaundice, nausea and vomiting. The mother noticed a slight unsteadiness in the gait, but this was not marked until he was about twelve years old. The eyes were slightly affected, so that he held his book to the left in reading, and noticed spots before his eyes; also complained of diplopia. He was confined to his bed, had very little pain, lay in a semi-comatose condition, had little or no vomiting. When he began to recover he remarked that all the days seemed dark. The sight was tested and it found that he could not count the fingers. This was after he had been ill for three or four weeks, and there was considerable bile in the blood and urine. His gait began to be more unsteady, the unsteadiness gradually in-